

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_  Male  Female SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_  Home  Cell  Work Alternate Phone: \_\_\_\_\_  Home  Cell  Work  
 Email: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Comorbidities: \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

## SHIPPING INFORMATION

Ship To:  Patient  Physician/Clinic  Realo Location: \_\_\_\_\_  
 Date Shipment Needed By: \_\_\_\_\_  Alternate Location: \_\_\_\_\_  
 Shipping Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

## DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis / ICD-10:  L40.0 Psoriasis  L40.59 Psoriatic Arthritis  L20 Atopic Dermatitis  L73.2 Hidradenitis Suppurativa  Other: \_\_\_\_\_  
 Has patient received PPD (tuberculosis) Skin Test? ( yes  no) Date of Negative Test: \_\_\_\_\_  
 Has Hepatitis B been ruled out? ( yes  no) If no, has treatment been initiated ( yes  no)  
 Does patient have a latex allergy: ( yes  no)  
 % BSA affected by Psoriasis: \_\_\_\_\_  
 Do the affected areas include the palms, soles, head, neck or genitalia? ( yes  no) Additional justification for drug: \_\_\_\_\_  
 Prior Failed Therapies:  Enbrel®  Stelara®  Humira®  
 Methotrexate®  Simponi®  PUVA  
 Topical: \_\_\_\_\_

## PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILL	DIRECTIONS
<input type="checkbox"/> Cosentyx® <input type="checkbox"/> Injection Training	Starter Dose: <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> 150 mg PFS	<input type="checkbox"/> 4 boxes		<input type="checkbox"/> 150 mg Sub-Q once weekly for 5 weeks
	<input type="checkbox"/> 2 x 150 mg (300mg) PFS			
	Maintenance Dose: <input type="checkbox"/> Sensoready Pen <input type="checkbox"/> 150 mg PFS	<input type="checkbox"/> 1 box		<input type="checkbox"/> 150 mg Sub-Q every 4 weeks
	<input type="checkbox"/> 2 x 150 mg (300mg) PFS			
<input type="checkbox"/> Cimzia® *only for PSA <input type="checkbox"/> Injection Training	Starter Dose: <input type="checkbox"/> Starter Kit (200 mg Prefilled Syringes)	<input type="checkbox"/> 1 Kit=6x200 mg/mL PFS		<input type="checkbox"/> 400 mg Sub-Q at weeks 0, 2, and 4
	<input type="checkbox"/> 200 mg lyophilized vial			
	Maintenance Dose: <input type="checkbox"/> 200 mg/mL PFS	<input type="checkbox"/> 1 Carton = 2x200 mg/mL PFS		<input type="checkbox"/> 400 mg Sub-Q every 4 weeks
	<input type="checkbox"/> 200mg lyophilized vial			
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 2 mL	<input type="checkbox"/> 2 PFS		<input type="checkbox"/> Starter Pack: 600 mg Sub-Q (given as two 300 mg injections) <input type="checkbox"/> Maintenance Dose: 300 mg Sub-Q once every other week
		<input type="checkbox"/> 2 Prefilled Pens		
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 25mg/mL vial kit	<input type="checkbox"/> 1 kit (4x1mL vials)		<input type="checkbox"/> Children/Adolescents <63kg: 0.8mg/kg once weekly <input type="checkbox"/> Psoriasis Induction Dose: Inject 50 mg Sub-Q twice a week (72-96 hours apart x 3 months) <input type="checkbox"/> Inject 50 mg Sub-Q ONCE a week
		<input type="checkbox"/> 8		
<input type="checkbox"/> Injection Training	<input type="checkbox"/> 50 mg/mL SureClick® Autoinjector	<input type="checkbox"/> 4		
	<input type="checkbox"/> Mini 50 mg Prefilled Cartridge	<input type="checkbox"/> 4		
	<input type="checkbox"/> 50 mg/mL PFS <input type="checkbox"/> 25 mg/0.5mL PFS			
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40 mg Pen <input type="checkbox"/> Citrate Free	<input type="checkbox"/> 1 kit		<input type="checkbox"/> Starter Pack: 80 mg Sub-Q Day 1, then 40 mg one week later (Day 8), then 40 mg every other week thereafter <input type="checkbox"/> Maint. Dose: 40 mg Sub-Q every two weeks
		<input type="checkbox"/> 2		
<input type="checkbox"/> Injection Training	<input type="checkbox"/> 40 mg PFS	<input type="checkbox"/> 4		<input type="checkbox"/> Starter Pack: 160 mg Sub-Q Day 1, then 80 mg 2 weeks later (Day 15) <input type="checkbox"/> Maint. Dose: 40 mg Sub-Q every week <input type="checkbox"/> Maint. Dose: 80mg Sub-Q every two weeks
	<input type="checkbox"/> 80 mg Pen	<input type="checkbox"/> 2		
<input type="checkbox"/> Humira® HS	<input type="checkbox"/> 40 mg Pen <input type="checkbox"/> Citrate Free	<input type="checkbox"/> 1 kit		
		<input type="checkbox"/> 4		
<input type="checkbox"/> Injection Training	<input type="checkbox"/> 40 mg PFS	<input type="checkbox"/> 2		
	<input type="checkbox"/> 80 mg Pen	<input type="checkbox"/> 2		
<input type="checkbox"/> Humira® HS	<input type="checkbox"/> 40 mg Pen <input type="checkbox"/> Citrate Free	<input type="checkbox"/> 1 kit		
		<input type="checkbox"/> 4		
<input type="checkbox"/> Injection Training	<input type="checkbox"/> 40 mg PFS	<input type="checkbox"/> 2		
	<input type="checkbox"/> 80 mg Pen	<input type="checkbox"/> 2		
<input type="checkbox"/> Ilumya®	<input type="checkbox"/> 100mg/mL PFS	<input type="checkbox"/> 1 PFS		<input type="checkbox"/> Starter Pack: 100 mg Sub-Q at weeks 0 and 4 <input type="checkbox"/> Maintenance Dose: 100 mg Sub-Q once every 12 weeks

Patient Eligible for Self-Injection?  Yes  No

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature

Date

Substitution Permissible - Signature

Date

**PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.**